DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 0 4 - 0 6

2. STATE: Missouri

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE: July 1, 2004

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR

7. FEDERAL BUDGET IMPACT:
a. FFY 2004 $ 0
b. FFY 2005 $ 0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-B: ~~XXX~~ pages 1c, 1d and 2

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19-B: pages 1c and 2
Missouri (04-06)
Approved: 09/10/04
Effective: 07/01/04

10. SUBJECT OF AMENDMENT: Revises section 11.B regarding ~~X~~ who qualifies as a nominal charge provider, adds language on how the prospective outpatient payment percentage will be determined for hospitals missing a ~~XXX~~ prior year cost report, and adds definition of nominal charge provider

11. GOVERNOR'S REVIEW *(Check One)*:

☒ GOVERNOR'S OFFICE REPORTED NO COMMENT ☐ OTHER, AS SPECIFIED:
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:
Steve Roling

14. TITLE:
Director

15. DATE SUBMITTED:
June 17, 2004

16. RETURN TO:
Department of Social Services
Division of Medical Services
P.O. Box 6500
Jefferson City, MO 65102

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: June 18, 2004

18. DATE APPROVED: SEP 10 2004

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: JUL 01 2004

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME: Thomas W. Lenz

22. TITLE: ARA For DMCH

23. REMARKS:

FORM HCFA-179 (07-92)

Instructions on Back

II Exempt Hospitals. Exempt Hospital Outpatient payment percent will be set as follows and will include:

A New Medicaid providers which do not have a fourth, fifth and sixth prior year cost report.

1. Interim payment percentage. An interim outpatient payment percentage for new Medicaid hospital providers will be set at seventy-five percent (75%) for the first three state fiscal years in which the hospital operates. The cost reports for these years will have a cost settlement calculated in accordance with Attachment 4.19B Appendix A.

2. Outpatient percentage. The outpatient payment percentage for the fourth and fifth year in which the hospital operates will be based on the overall Medicaid cost-to-charge ratio from its fourth prior year cost report.

B Hospitals who qualify as nominal charge providers under 42 CFR 413.13(f) or meet the definition of nominal charge provider in subsection IV.D shall be reimbursed on an interim basis by Medicaid at the lesser of seventy-five percent (75%) of usual and customary charges as billed by the provider for covered services or one hundred percent (100%) of the facility's Medicaid-allowable outpatient cost-to-charge ratio as determined from the most recent desk-reviewed cost report. Reimbursement at the applicable percentage shall be effective July 1 of each SFY for all providers.

C A hospital which had a change in ownership or merged its operation with another hospital between January 1, 1997 and June 30, 2002, and does not have a 1997 cost report filed by new owner, shall have the option to delay its entry into prospective outpatient payment methodology or enter the prospective outpatient payment methodology identified in subsection I.A. of this regulation. The hospital must notify the Division of its decision by March 3, 2003. A hospital which chooses to delay its entry into the prospective outpatient payment methodology will receive an outpatient payment percentage effective July 1, 2002 in accordance with section II.C.1., and will have final settlements calculated in accordance with Attachment 4.19B Appendix A. The transfer to the prospective outpatient payment percentage will occur as follows:

1. A hospital which does not have a fourth prior year cost report (for SFY 2003 cost report would be 1999) filed by new owner will have its retrospective outpatient payment percentage based on the overall outpatient cost-to- charge ratio from the most current desk reviewed cost report, either prior or current owner. All cost reports for prior and current owner ending in the SFY prior to the year the new owner receives a prospective outpatient payment percentage in accordance with paragraph II.C.2., will have a final settlement calculated in accordance with Attachment 4:19B Appendix A, and;

2. A hospital which has a fourth prior year cost report filed by current owner will have its prospective outpatient payment percentage based on the overall outpatient cost-to-charge ratio from its fourth prior year cost report for the fourth and fifth SFY after the change in ownership or merger which occurred prior to July 1, 2002. For the sixth SFY the hospital's rate will be established in accordance with subsection I.A. of this regulation.

Chart for prospective rates for change in ownership or merger:

1st cost report filed calendar year	Settlement calculated	SFY	SFY Prospective rate granted	Cost reports used for Prospective rate
1998	Yes	1998	No	
1999	Yes	1999	No	
2000	Yes	2000	No	
2001	No	2001	No	
2002	No	2002	No	
2003	No	2003	Yes	1999
N/A	No	2004	Yes	1998, 1999 & 2000
N/A	No	2005	Yes	1999, 2000 & 2001

D A hospital that has failed to file one of the cost reports used to determine their prospective outpatient payment percentage for the year, whether it be the fourth (4th), fifth (5th), or sixth (6th) prior year cost report, will have their prospective outpatient payment percentage based on the two cost reports that are on file with the Division plus the average of those two cost reports to be used in place of the missing cost report. For example, if the Division does not have on file a fourth (4th) prior year cost report but has the fifth (5th) and sixth (6th) prior year cost reports, an average of the fifth (5th) and sixth (6th) prior year cost reports would be used in place of the fourth (4th) prior year cost report. This average along with the fifth (5th) and sixth (6th) prior year cost reports would then be used to calculate the prospective outpatient payment percentage.

III Closed facilities. Hospitals which closed after January 1, 1999 but before July 2, 2002 will have final settlements for cost reports ending during this time period calculated in accordance with Attachment 4.19B Appendix A.

IV Definitions

A Base cost report. Desk-reviewed Medicare/Medicaid cost report. When a facility has more than one (1) cost report with periods ending in the fourth prior calendar year, the cost report covering a full twelve (12)-month period will be used. If none of the cost reports cover a full twelve (12) months, the cost report with the latest period will be used. If a hospital's base cost report is less than or greater than a twelve (12)-month period, the data shall be adjusted, based on the number of months reflected in the base cost report to a twelve (12)-month period.

B Cost report. A cost report details, for purposes of both Medicare and Medicaid reimbursement, the cost of rendering covered services for the fiscal reporting period. The Medicare/Medicaid Uniform Cost Report contains the form utilized in filing the cost report.

C Effective date.
1. The plan effective date shall be July 1, 2002.
2. New prospective outpatient payment percentages will be effective July 1 of each SFY.

D Nominal charge provider. A nominal charge provider is determined from the fourth (4^{th}) prior year desk reviewed cost report. The hospital must meet the following criteria:
1. An acute care hospital with an unsponsored care ratio of at least sixty-five percent (65%) and is licensed for fifty (50) inpatient beds or more and has an occupancy rate of more than forty percent (40%). The unsponsored care ratio is determined as the sum of bad debts and charity care divided by total net revenue. The hospital must meet one of the federally mandated Disproportionate Share qualifications; or
2. The hospital is a public hospital operated by the Department of Mental Health primarily for the care and treatment of mental disorders.